WISCONSIN ADULT LONG TERM CARE FUNCTIONAL SCREEN – VERSION 3

Screening Agency:	Referral Date: (mm/dd/yyyy) / /
Screener's Name:	

SCREEN TYPE: (Check only **one** box.)

- ☐ 01 Initial screen
- ☐ 02 Annual screen
- ☐ 03 Screen due to change in condition or situation (or by request)

Was this person offered this functional screen in response to a referral from a nursing home, CBRF, RCAC, or Adult Family Home to a Family Care resource center (PAC)?

☐ (If yes, check this box. If no, leave blank.)

Applicant Name: (Print clearly)

First Name:	**Middle Name**:	**Last Name**:
Gender: ☐ M = Male ☐ F = Female	**Social Security #** -- --	**Date of Birth** (mm/dd/yyyy) / /

APPLICANT'S ADDRESS:

_____

_____

Telephone Number: (_____)_____

County / Tribe of Residence: _____ County / Tribe of Responsibility: _____

Directions: _____

_____

TRANSFER INFORMATION

TO BE COMPLETED AFTER ELIGIBILITY DETERMINATION AND ENROLLMENT COUNSELING, AND AFTER PERSON CHOOSES TO ENROLL IN A LTC PROGRAM.

REFERRAL DATE to SERVICE AGENCY: (mm/dd/yyyy) _____/_____/_____

SERVICE AGENCY: _____

SCREEN INFORMATION

REFERRAL SOURCE: (Check only **one** box.)

- ☐ Self
- ☐ Family/Significant Other
- ☐ Friend/Neighbor/Advocate
- ☐ Physician/Clinic
- ☐ Hospital Discharge Staff
- ☐ Nursing Home
- ☐ CBRF (Group Home)
- ☐ AFH (Adult Family Home)
- ☐ RCAC (Residential Care Apartment Complex)
- ☐ ICF-MR/FDD
- ☐ State Center
- ☐ Home Health Agency
- ☐ Community Agency
- ☐ Other: (Specify.) _____
- ☐ Annual Recertification or Change in Condition

PRIMARY SOURCE FOR SCREEN INFORMATION: (Check only **one** box.)

- ☐ Individual **If other, their name(s):** _____
- ☐ Guardian
- ☐ Family Member
- ☐ Spouse/Significant Other
- ☐ Parent
- ☐ Child
- ☐ Advocate
- ☐ Case Manager
- ☐ Hospital Staff
- ☐ Nursing Home Staff
- ☐ ICF-MR/Center Staff
- ☐ CBRF Staff
- ☐ AFH Staff
- ☐ Home Health, Personal Care, or Supportive Home Care Staff

☐ Other: (Specify.) _____

WHERE SCREEN INTERVIEW WAS CONDUCTED:

- ☐ Person's Current Residence
- ☐ Temporary Residence (non-institutional)
- ☐ Nursing Home
- ☐ Hospital
- ☐ Agency Office, Resource Center

☐ Other: (Specify.) _____

TARGET GROUP:

At least one box must be checked. If "No Target Group" is checked, then no other box should be checked.

This person has a condition related to: (Refer to the definitions on the last page of the screen and to the instructions.)

- ☐ Frail Elder
- ☐ Physical disability
- ☐ Developmental disability per FEDERAL definition
- ☐ Developmental disability per STATE definition but NOT federal definition
- ☐ Alzheimer's disease or other irreversible dementia (onset of any age)
- ☐ A terminal condition with death expected within one year from the date of this screening
- ☐ Severe and persistent mental illness
- ☐ None of the above (No Target Group)

Is the condition related to the eligible target group expected to last more than 12 months OR does the person have a terminal illness?

- ☐ Yes
- ☐ No

Is the condition related to the eligible target group expected to last more than 90 days?

- ☐ Yes
- ☐ No

Does the applicant have a disability determination from the Disability Determination Bureau or the Social Security Administration?

- ☐ Yes
- ☐ No
- ☐ Pending

HCB Waiver Group: **(For Home and Community Based Waiver counties only)**

- ☐ CIP 1A
- ☐ CIP 1B
- ☐ COP W & CIP II

DEMOGRAPHICS

MEDICAL INSURANCE: (Check **all** that apply. Write numbers **clearly**.)

- ☐ Medicare # _____
  - ☐ Part A **Effective Date**: _____
  - ☐ Part B **Effective Date**: _____
  - ☐ Medicare Managed Care
- ☐ Medicaid # _____
- ☐ Private Insurance (includes employer-sponsored [job benefit] insurance)
- ☐ Private Long Term Care Insurance
- ☐ Railroad Retirement # _____
- ☐ Other Insurance
- ☐ No medical insurance at this time.

RACE: (Optional. Check all boxes that apply.)

- ☐ Black or African American
- ☐ Asian or Pacific Islander
- ☐ White
- ☐ American Indian or Alaskan Native
- ☐ Other: _____

ETHNICITY: (Optional)

- ☐ Spanish / Hispanic / Latino

AN INTERPRETER IS REQUIRED: If so, in what language?

- ☐ American Sign Language
- ☐ Spanish
- ☐ Vietnamese
- ☐ Hmong
- ☐ Russian
- ☐ Other: _____
- ☐ A Native American Language

CONTACT INFORMATION 1:

Contact Type:

- ☐ Adult Child
- ☐ Ex-Spouse
- ☐ Guardian of Person
- ☐ Parent/Step-Parent
- ☐ Power of Attorney
- ☐ Sibling
- ☐ Spouse
- ☐ Other Informal Caregiver/Support:_____

First Name: _____ Middle Initial: ____ Last Name: _____

Phone Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Comments: _____

CONTACT INFORMATION 2:

Contact Type:

- ☐ Adult Child
- ☐ Ex-Spouse
- ☐ Guardian of Person
- ☐ Parent/Step-Parent
- ☐ Power of Attorney
- ☐ Sibling
- ☐ Spouse
- ☐ Other Informal Caregiver/Support:_____

First Name: _____ Middle Initial: ____ Last Name: _____

Phone Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Comments: _____

CONTACT INFORMATION 3:

Contact Type:

- ☐ Adult Child
- ☐ Ex-Spouse
- ☐ Guardian of Person
- ☐ Parent/Step-Parent
- ☐ Power of Attorney
- ☐ Sibling
- ☐ Spouse
- ☐ Other Informal Caregiver/Support:_____

First Name: _____ Middle Initial: ____ Last Name: _____

Phone Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Comments: _____

RESIDENCE: On this table, make **ONLY ONE** check-mark to indicate where the person lives now, and **ONLY ONE** check-mark to indicate where the person would like to live. For the latter, record the person's preference, not what is deemed realistic (e.g., safe, cost-effective), and not what anyone else prefers.

NOW LIVES	LIVING SITUATION	PREFERS TO LIVE
	OWN HOME OR APARTMENT	
☐	Alone (includes person living alone who receives in-home services)	☐
☐	With Spouse/Partner/Family	☐
☐	With Non-relatives/Roommates	☐
☐	With Live-in Paid Caregiver(s) (includes service in exchange for room & board)	☐
	SOMEONE ELSE'S HOME OR APARTMENT	
☐	Family	☐
☐	Non-relative	☐
☐	Paid Caregiver's Home (e.g., 1-2 bed adult family home, or child foster care)	☐
☐	Home/Apartment for which lease is held by support services provider	☐
	APARTMENT WITH SERVICES	
☐	Residential Care Apartment Complex	☐
☐	Independent Apartment CBRF (Community-Based Residential Facility)	☐
	GROUP RESIDENTIAL CARE SETTING	
☐	Licensed Adult Family Home (3-4 bed AFH)	☐
☐	CBRF 1-20 beds	☐
☐	CBRF more than 20 beds	☐
☐	Children's Group Home	☐
	HEALTH CARE FACILITY / INSTITUTION	
☐	Nursing Home	☐
☐	ICF- MR/FDD	☐
☐	DD Center/State institution for developmental disabilities	☐
☐	Mental Health Institute/State psychiatric institution	☐
☐	Other IMD	☐
☐	Child Caring Institution	☐
☐	No permanent residence (e.g., is in homeless shelter, etc.)	☐
☐	OTHER (includes jail) Specify:_____	
	Unable to determine person's preference for living arrangement.	☐

What is the guardian's/ family's preference for living arrangements for this individual?

- ☐ Not Applicable
- ☐ Stay at current residence
- ☐ Move to own home/apartment (includes living with spouse/family, roommates, 1-2 bed AFH)
- ☐ Move to an apartment with onsite services (RCAC, independent apartment CBRF)
- ☐ Move to a group residential care setting (CBRF, licensed 3-4 bed AFH)
- ☐ Move to a nursing home or other health care facility (ICFMR, State Center, IMD)
- ☐ Unsure, or unable to determine
- ☐ No consensus among multiple parties

ADLs (Activities of Daily Living)

DETAILS OF LEVEL OF HELP NEEDED TO COMPLETE TASK SAFELY:

0	**Person is independent in completing the activity safely.**
1	Help is needed to complete task safely but helper DOES NOT have to be physically present throughout the task. "Help" can be supervision, cueing, or hands-on assistance.
2	Help is needed to complete task safely and helper DOES need to be present throughout task. "Help" can be supervision, cueing, and/or hands-on assistance (partial or complete).

CODING FOR WHO WILL HELP IN NEXT 8 WEEKS: (Check all that apply.)

U	Current **UNPAID** caregiver will continue
PP	Current **PRIVATELY PAID** caregiver will continue
PF	Current **PUBLICLY FUNDED** paid caregiver will continue
N	**Need** to find new or additional caregiver(s)

ADLs (Activities of Daily Living)	Help Needed (Check only one)	Who Will Help in Next 8 weeks? (Check all that apply)
BATHING: The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene. *This also includes the ability to get in and out of the tub, turn faucets on & off, regulate water temperature, wash and dry fully.* ☐ **USES SHOWER CHAIR, TUB BENCH, GRAB BARS, OR MECHANICAL LIFT**	☐ **0** ☐ **1** ☐ **2**	☐ **U** ☐ **PP** ☐ **PF** ☐ **N**
DRESSING: The ability to dress and undress as necessary and choose appropriate clothing. Includes the ability to put on prostheses, braces, antiembolism hose (e.g., "TED" stockings) with or without assistive devices, and includes fine motor coordination for buttons and zippers. *Includes choice of clothing appropriate for the weather. Difficulties with a zipper or buttons **at the back** of a dress or blouse do not constitute a functional deficit.*	☐ **0** ☐ **1** ☐ **2**	☐ **U** ☐ **PP** ☐ **PF** ☐ **N**
EATING: The ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew, and swallow food. *Note: If person is fed via tube feedings or intravenous, check box 0 if they can do themselves, or box 1 or 2 if they require another person to assist.*	☐ **0** ☐ **1** ☐ **2**	☐ **U** ☐ **PP** ☐ **PF** ☐ **N**
MOBILITY IN HOME: The ability to move between locations in the individual's living environment - defined as kitchen, living room, bathroom, and sleeping area. *This excludes basements, attics, yards, and any equipment used outside the home.* ☐ **USES WALKER, CANE, QUAD-CANE, OR CRUTCHES IN HOME** ☐ **USES WHEELCHAIR OR SCOOTER IN HOME** ☐ **HAS PROSTHESIS**	☐ **0** ☐ **1** ☐ **2**	☐ **U** ☐ **PP** ☐ **PF** ☐ **N**

ADLs (Activities of Daily Living) (Continued)	**Help Needed** (Check only one)	**Who Will Help in Next 8 weeks?** (Check all that apply)
TOILETING: The ability to use the toilet, commode, bedpan, or urinal. *This includes transferring on/off the toilet, cleansing of self, changing of pads, managing an ostomy or catheter, and adjusting clothes.* ☐ **USES COMMODE OR OTHER ADAPTIVE EQUIPMENT, INCLUDING GRAB BARS** ☐ **HAS OSTOMY** ☐ **USES URINARY CATHETER** ☐ **RECEIVES REGULAR BOWEL PROGRAM** **INCONTINENCE**: Do not include stress incontinence (small amounts of urine leaking during sneezing, coughing, or other exertion) ☐ **APPLICANT DOES NOT HAVE INCONTINENCE** ☐ **HAS INCONTINENCE DAILY** ☐ **HAS INCONTINENCE LESS THAN DAILY BUT AT LEAST ONCE PER WEEK**	☐ **0** ☐ **1** ☐ **2**	☐ **U** ☐ **PP** ☐ **PF** ☐ **N**
TRANSFERRING: The physical ability to move between surfaces: from bed/chair to wheelchair, walker or standing position. The ability to get in and out of bed or usual sleeping place. The ability to use assistive devices for transfers. *Excludes toileting transfers.* ☐ **USES MECHANICAL LIFT** (not a lift chair) ☐ **USES TRANSFER BOARD, TRAPEZE OR GRAB BARS**	☐ **0** ☐ **1** ☐ **2**	☐ **U** ☐ **PP** ☐ **PF** ☐ **N**

IADLs (Instrumental Activities of Daily Living)

CODING FOR WHO WILL HELP IN NEXT 8 WEEKS: (Check **all** that apply.)

U	Current **UNPAID** caregiver will continue
PP	Current **PRIVATELY PAID** caregiver will continue
PF	Current **PUBLICLY FUNDED** paid caregiver will continue
N	**Need** to find new or additional caregiver(s)

IADL	Level of Help Needed	Who Will Help in Next 8 weeks?
MEAL PREPARATION	☐ 0 Independent ☐ 1 Needs help from another person weekly or less often ☐ 2 Needs help 2 to 7 times a week—(to prepare or help with meal preparation or provide meals) ☐ 3 Needs help with every meal (to provide, prepare or help prepare)	☐ **U** ☐ **PP** ☐ **PF** ☐ **N**
MEDICATION MANAGEMENT and ADMINISTRATION	☐ NA - Has no medications. ☐ 0 Independent (with or without assistive devices). ☐ 1 Needs help 1-2 days per week or less often. Includes having someone set up meds (e.g., in blister packs or med box) or pre-filling syringes, or administration of medicine. ☐ 2a Needs help at least once a day 3-7 days per week – CAN direct the task and can make decisions regarding each medication. ☐ 2b Needs help at least once a day 3-7 days per week – CANNOT direct the task; is cognitively unable to follow through without another person to administer each medication.	☐ **U** ☐ **PP** ☐ **PF** ☐ **N**
MONEY MANAGEMENT	☐ 0 Independent ☐ 1 Needs help from another person weekly or less ☐ 2 Needs help from another person daily or more often (e.g., with every transaction)	☐ **U** ☐ **PP** ☐ **PF** ☐ **N**
LAUNDRY &/OR CHORES	☐ 0 Independent ☐ 1 Needs help from another person weekly or less often ☐ 2 Needs help more than once a week *Chores = Housekeeping, home maintenance, shoveling, etc.*	☐ **U** ☐ **PP** ☐ **PF** ☐ **N**

TELEPHONE	**1. Ability to Use Phone:** ☐ 1a Independent. Has cognitive and physical abilities to make calls and answer calls (with assistive devices currently used by this person) ☐ 1b Lacks cognitive or physical abilities to use phone independently **2. Access to Phone:** ☐ 2a Currently has working telephone or access to one ☐ 2b Has no phone and no access to phone
TRANSPORTATION	**Person drives:** ☐ 1a Person drives regular vehicle ☐ 1b Person drives adapted vehicle ☐ 1c Person drives regular vehicle, but there are serious safety concerns ☐ 1d Person drives adapted vehicle, but there are serious safety concerns ☐ **2 Person can not drive due to physical, psychiatric, or cognitive impairment.** *Includes no driver's license due to medical problems (e.g., seizures, poor vision).* ☐ **3 Person does not drive due to other reasons**

OVERNIGHT CARE / EMPLOYMENT

DOES PERSON REQUIRE OVERNIGHT CARE OR SUPERVISION?

☐ 0 No

☐ 1 Yes; caregiver can get at least 6 hours of uninterrupted sleep per night.

☐ 2 Yes; caregiver cannot get at least 6 hours of uninterrupted sleep per night.

EMPLOYMENT: The ability to function at a job site. *This question concerns the need for employment-related assistance. Since the need for help with ADLs and IADLs is captured in other sections, this question essentially covers job coach duties.*

A. CURRENT EMPLOYMENT STATUS & INTEREST	☐ 1 Retired ☐ 2 Not employed ☐ 3 Employed full time ☐ 4 Employed part-time	**Check one of the two boxes below (required)**: ☐ I -- Interested in new job ☐ N –Not interested in new job
B. IF EMPLOYED, WHERE	☐ 1 Attends pre-vocational day activity/work activity program ☐ 2 Attends sheltered workshop ☐ 3 Has a paid job in the community ☐ 4 Works at home	
C. NEED FOR ASSISTANCE TO WORK (**Optional** for unemployed persons)	☐ 0 Independent (with assistive devices if uses them) ☐ 1 Needs help weekly or less (e.g., if problems arise) ☐ 2 Needs help every day but does not need the continuous presence of another ☐ 3 Needs the continuous presence of another person	

DIAGNOSES

Diagnoses: Check diagnosis here if (1) it is provided by a health care provider, or (2) you see it written in a medical record (including hospital discharge forms, nursing home admission forms, etc.), or (3) if person or informant can state them **EXACTLY** - except for psychiatric diagnoses, which must be confirmed by health care personnel or records. Do not try to interpret people's complaints or medical histories. Contact health providers instead.

☐ **NO Current Diagnoses** (screen type must be 01)

A. DEVELOPMENTAL DISABILITY

☐ 1 Mental Retardation
☐ 2 Autism
☐ 3 Brain Injury **with onset before age 22**
☐ 4 Cerebral Palsy
☐ 5 Prader-Willi Syndrome
☐ 6 Seizure Disorder **with onset before age 22**
☐ 7 Otherwise meets state or Fed. definitions of DD

B. ENDOCRINE / METABOLIC

☐ 1 Diabetes Mellitus
☐ 2 Hypothyroidism/ Hyperthyroidism
☐ 3 Dehydration/ fluid & electrolyte imbalances
☐ 4 Liver Disease (hepatic failure, cirrhosis)
☐ 5 Other disorders of digestive system (mouth, esophagus, stomach, intestines, gall bladder, pancreas)
☐ 6 Nutritional Imbalances (e.g, malnutrition, vitamin deficiencies, high cholesterol, Hyperlipidemia)
☐ 7 Other disorders of hormonal or metabolic system

C. HEART / CIRCULATION

☐ 1 Anemia/Coagulation Defects/Other blood diseases
☐ 2 Angina/Coronary Artery Disease/Myocardial Infarction (MI)
☐ 3 Disorders of heart rate or rhythm
☐ 4 Congestive Heart Failure (CHF)
☐ 5 Disorders of blood vessels or lymphatic system
☐ 6 Hypertension (HTN) (high blood pressure)
☐ 7 Hypotension (low blood pressure)
☐ 8 Other heart conditions (including valve disorders)

D. MUSCULOSKELETAL / NEUROMUSCULAR

☐ 1 Amputation
☐ 2 Arthritis (e.g., Osteoarthritis, Rheumatoid Arthritis)
☐ 3 Hip fracture/ replacement
☐ 4 Other fracture/ joint disorders/ Scoliosis/ Kyphosis
☐ 5 Osteoporosis/ Other bone disease
☐ 6 Contractures/ Connective Tissue Disorders
☐ 7 Multiple Sclerosis/ ALS
☐ 8 Muscular Dystrophy
☐ 9 Spinal Cord Injury
☐ 10 Paralysis Other than Spinal Cord Injury
☐ 11 Spina Bifida
☐ 12 Other chronic pain or fatigue (e.g., Fibromyalgia, Migraines, headaches, back pain [including discs], CFS)
☐ 13 Other Musculoskeletal, Neuromuscular, or Peripheral Nerve Disorders

E. BRAIN / CENTRAL NERVOUS SYSTEM

☐ 1 Alzheimer's Disease
☐ 2 Other Irreversible Dementia
☐ 3 Cerebral Vascular Accident (CVA, stroke)
☐ 4 Traumatic Brain Injury **after age 22**
☐ 5 Seizure Disorder **with onset after age 22**
☐ 6 Other brain disorders

F. RESPIRATORY

☐ 1 Asthma/ Chronic Obstructive Pulmonary Disease (COPD)/ Emphysema/ Chronic Bronchitis
☐ 2 Pneumonia/Acute Bronchitis/ Influenza
☐ 3 Tracheostomy
☐ 4 Ventilator Dependent
☐ 5 Other respiratory condition

G. DISORDERS OF GENITOURINARY SYSTEM / REPRODUCTIVE SYSTEM

☐ 1 Renal Failure, other kidney disease
☐ 2 Urinary Tract Infection, current or recently recurrent
☐ 3 Other disorders of GU system (bladder, urethra)
☐ 4 Disorders of reproductive system

H. DOCUMENTED MENTAL ILLNESS

☐ 1 Anxiety Disorder (e.g., phobias, post- traumatic stress disorder, Obsessive-Compulsive Disorder)
☐ 2 Bipolar/Manic-Depressive
☐ 3 Depression
☐ 4 Schizophrenia
☐ 5 Other **Mental Illness Diagnosis** (e.g., Personality Disorder)

I. SENSORY

☐ 1 Blind
☐ 2 Visual impairment (e.g., cataracts, retinopathy, glaucoma, macular degeneration)
☐ 3 Deaf
☐ 4 Other sensory disorders

J. INFECTIONS / IMMUNE SYSTEM

☐ 1 Allergies
☐ 2 Cancer in past 5 years
☐ 3 Diseases of skin
☐ 4 HIV Positive
☐ 5 AIDS (diagnosed)
☐ 6 Other infectious disease
☐ 7 Auto-Immune Disease (other than rheumatism)

K. OTHER

☐ 1 Alcohol or Drug Abuse
☐ 2 Behavioral diagnoses (not found in Part H above)
☐ 3 Terminal Illness (prognosis ≤ 12 months)
☐ 4 Wound, Burn, Bedsore, Pressure Ulcer
☐ 5 OTHER: Be sure to review " Cue Sheet"

HEALTH RELATED SERVICES

Check only one box per row. Leave row blank if not applicable.

HEALTH-RELATED SERVICES NEEDED	PERSON IS INDEPEN-DENT	FREQUENCY OF HELP/SERVICES NEEDED FROM OTHER PERSONS					
		1 to 3 times/ Month	Weekly	2 to 6 times/ week	1 to 2 times a day	3 to 4 times a day	Over 4 times a day
BEHAVIORS requiring interventions (wandering, SIB, offensive/violent behaviors)							
Requires **NURSING ASSESSMENT** (e.g., RN visits) and interventions because person is unable to self manage current health conditions or health risks. 'Unable to self-manage' means the person: a. Is unable to recognize problems. b. Is unable to respond to problems c. Does not know contributing factors or corrective actions, **OR** d. Has history of failure to self-manage health resulting in multiple ER visits or hospitalizations.							
EXERCISES/RANGE OF MOTION							
IV MEDICATIONS, Fluids or IV Line Flushes							
MEDICATION ADMINISTRATION (not IV). Includes assistance with pre-selected or set-up meds							
MEDICATION MANAGEMENT – Set-up and/or monitoring (for effects, side effects, adjustments, pain management) -- AND/OR blood levels (e.g., drawing blood sample for laboratory tests or "finger-sticks" for blood sugar levels.)							
OSTOMY-RELATED SKILLED SERVICES							
POSITIONING IN BED OR CHAIR every 2-3 hours							
OXYGEN and/or RESPIRATORY TREATMENTS: Tracheal suctioning, C-PAP, Bi-PAP, Nebulizers, IPPB treatments (does NOT include inhalers)							
DIALYSIS							
TPN (Total Parenteral Nutrition)							
TRANSFUSIONS							
TRACHEOSTOMY CARE							
TUBE FEEDINGS							
ULCER – Stage 2							
ULCER – Stage 3 or 4							
URINARY CATHETER-RELATED SKILLED TASKS (irrigation, straight catheterizations)							
OTHER WOUND CARES (not catheter sites, ostomy sites, or IVs, or ulcers)							
VENTILATOR-RELATED INTERVENTIONS							
OTHER (Specify.):							

SKILLED THERAPIES – PT, OT, ST (Any one or a combination, at any location)	**5 + days/week**	**1 to 4 days/week**

Coding for who will help with all health-related needs in next 8 weeks: (Check **all** that apply.)

- ☐ **U** Current UNPAID caregiver will continue
- ☐ **PP** Current PRIVATELY PAID caregiver will continue
- ☐ **PF** Current PUBLICLY FUNDED paid caregiver will continue
- ☐ **N** Need to find new (or additional) caregiver

COMMUNICATION AND COGNITION

COMMUNICATION: (Check only **one** box.)

Includes the ability to express oneself in one's own language, including non-English languages and American Sign Language (ASL) or other generally recognized non-verbal communication. This includes the use of assistive technology.

- ☐ 0 Can fully communicate with no impairment or only minor impairment (e.g., slow speech)
- ☐ 1 Can fully communicate with the use of assistive device
- ☐ 2 Can communicate **only basic** needs to others
- ☐ 3 No effective communication

MEMORY LOSS: (At least one box must be checked. If "0 No memory impairments evident" is checked, then no other box should be checked.)

- ☐ 0 No memory impairments evident during screening process or unknown or unable to determine
- ☐ 1 Short Term Memory Loss (seems unable to recall things a few minutes later)
- ☐ 2 Unable to remember things over several days or weeks
- ☐ 3 Long Term Memory Loss (seems unable to recall distant past)

COGNITION FOR DAILY DECISION MAKING: (Check only **one**.)

(Beyond medications and finances, which are captured elsewhere)

- ☐ 0 **Independent** - Person can make decisions that are generally consistent with her/his own lifestyle, values, and goals (not necessarily with professionals' values and goals)
- ☐ 1 Person can make safe decisions in **familiar/routine situations**, but needs some help with decision-making when faced with new tasks or situations
- ☐ 2 Person needs help with reminding, planning, or adjusting routine, **even with familiar routine**
- ☐ 3 Person **needs help** from another person most or all of the time

PHYSICALLY RESISTIVE TO CARE: (Check only **one**.)

- ☐ 0 No
- ☐ 1 Yes, person is physically resistive to cares due to a cognitive impairment
- ☐ 2 Unknown

BEHAVIORS / MENTAL HEALTH

WANDERING: Defined as a person with cognitive impairments leaving residence/immediate area without informing others. *Person may still exhibit wandering behavior even if elopement is impossible due to, for example, facility security systems.*

- ☐ 0 Does not wander
- ☐ 1 Daytime wandering but sleeps nights
- ☐ 2 Wanders at night or day and night

SELF-INJURIOUS BEHAVIORS: Behaviors that cause or could cause injury to one's own body. *Examples include physical self-abuse (hitting, biting, head banging, etc.), pica (eating inedible objects), and water intoxication (polydipsia).*

- ☐ 0 No injurious behaviors demonstrated
- ☐ 1 Some self-injurious behaviors require interventions **weekly or less**
- ☐ 2 Self-injurious behaviors require interventions 2-6 times per week **OR** 1-2 times per day
- ☐ 3 Self-injurious behaviors require intensive 1-on-1 interventions more than twice each day

OFFENSIVE OR VIOLENT BEHAVIOR TO OTHERS: Behavior that causes pain or distress to others or interferes with activities of others.

- ☐ 0 No offensive or violent behaviors demonstrated
- ☐ 1 Some offensive or violent behaviors require occasional interventions **weekly or less**
- ☐ 2 Offensive or violent behaviors require interventions 2-6 times per week **OR** 1-2 times per day
- ☐ 3 Offensive or violent behaviors require intensive one-on-one interventions more than twice each day

MENTAL HEALTH NEEDS: (Check **only one** of the 4 boxes below.)

NO KNOWN DIAGNOSIS OF MENTAL ILLNESS:

- ☐ 0 No mental health problems or needs evident. *No symptoms that may be indicative of mental illness; not on any medications for psychiatric diagnosis.*
- ☐ 1 Person may be at risk and in need of some mental health services. Examples could include symptoms or reports of problems that may be related to mental illness, or requests for help by the person or family/advocates, or risk factors for mental illness. *Examples of risk factors are symptoms of clinical depression that have lasted more than 2 weeks and/or interfere with daily life, recent trauma or loss.*

PERSON HAS CURRENT DIAGNOSIS OF MENTAL ILLNESS:

- ☐ 2 Is currently stable (with or without medications). *"Stable" here means the person is functioning well with routine periodic oversight/support, and is currently receiving such oversight/support.*
- ☐ 3 Is currently not stable. *Needs intensive mental health services (whether they're currently getting them or not, they need them).*

SUBSTANCE ABUSE: (More than one box may be checked, if appropriate.)

- ☐ 0 No active substance abuse problems evident at this time.
- ☐ 1 Person or others indicate(s) a current problem, or evidence suggests possibility of a current problem or high likelihood of recurrence without significant on-going support or interventions.
- ☐ 2 In the past year, the person has had significant problems due to substance abuse. *Examples are police interventions, detox, inpatient treatment, job loss, major life changes.*

RISK

PART A – CURRENT APS OR EAN CLIENT:

☐ A1 Person is known to be a current client of Adult Protective Services (APS)

☐ A2 Person is currently being served by the lead Elder Abuse and Neglect (EAN) agency. *Refer to local APS unit to determine whether this EAN client has current APS needs for eligibility purposes.*

PART B - RISK EVIDENT DURING SCREENING PROCESS:

At least one box must be checked. Do not check boxes 1, 2 or 3 if checking box "0".

☐ 0 No risk factors or evidence of abuse or neglect apparent at this time.

☐ 1 The individual is currently failing or is at high risk of failing to obtain nutrition, self-care, or safety adequate to avoid significant negative health outcomes.

☐ 2 The person is at imminent risk of institutionalization in a nursing home or ICF-MR if s/he does not receive needed assistance OR is currently residing in an institution.

☐ 3 There are statements of, or evidence of, possible abuse, neglect, self-neglect, or financial exploitation.
If yes:
- ☐ Referring to APS and/or EAN now
- ☐ Not referring at this time, because competent adult refuses to allow referral.

Comments:

☐ 4 The person's support network appears to be adequate at this time, but may be fragile in the near future (within next 4 months).

SCREEN COMPLETION

GRANDFATHERING: (For Family Care CMO counties only)

Is person eligible for Grandfathering into Family Care (per county list)?

- ☐ 1 Yes
- ☐ 2 No

SCREEN COMPLETION DATE: mm/dd/yyyy _____ / _____ / _____

TIME TO COMPLETE SCREEN:

FACE-TO-FACE CONTACT WITH THE PERSON:
This can include an in-person interview, or observation if person cannot participate in interview.
_____Hrs _____Mins

COLLATERAL CONTACTS:
Either in-person or indirect contact with any other people, including family, advocates, providers, etc.
_____Hrs _____Mins

PAPER WORK:
Includes review of medical documents, COP assessment, etc.
_____Hrs _____Mins

TRAVEL TIME:
_____Hrs _____Mins

TOTAL TIME TO COMPLETE SCREEN:
_____Hrs _____Mins

NOTES:

COP LEVEL 3 and NAT

COP Level 3: (for Home and Community Based Waiver counties only)

Part A. Alzheimer's and related diseases:

1. The person has a physician's written and dated statement that the person has Alzheimer's and/or another qualifying irreversible dementia.
   ☐ NA ☐ Yes ☐ No

2. The person needs personal assistance, supervision and protection, and periodic medical services and consultation with a registered nurse, or periodic observation and consultation for physical, emotional, social or restorative need, but not regular nursing care.
   ☐ NA ☐ Yes ☐ No

Part B. Interdivisional Agreement 1.67

1. The person resided in a nursing home or received CIP II/COP-W services and was referred through Interdividsional Agreement 1.67 in accordance with s. 46.27(6r)(b)(3).
   ☐ NA ☐ Yes ☐ No

NO ACTIVE TREATMENT: (for Family Care CMO counties only)

Part A. Criteria that can be documented prior to enrollment:

1. The person has a terminal illness.
   ☐ NA ☐ Yes ☐ No

2. The person has an IQ above 75 (RC will pass documentation on to CMO for their records if person enrolls).
   ☐ NA ☐ Yes ☐ No

3. The person is ventilator dependent.
   ☐ NA ☐ Yes ☐ No

Part B. Criteria that can be documented only after enrollment based on the interdisciplinary team assessment:

1. The person has physical and mental incapacitation due to advanced age such that his/her needs are similar to those of geriatic nursing home residents.
   ☐ NA ☐ Yes ☐ No

2. The person is elderly (generally over age 65) and would no longer benefit from active treatment.
   ☐ NA ☐ Yes ☐ No

3. The person has chronic severe medical needs that require skilled nursing level of care.
   ☐ NA ☐ Yes ☐ No

Definitions for Target Group Question

REFER TO LTC FS INSTRUCTIONS

FRAIL ELDER means an individual aged 65 or older who has a physical disability, or irreversible dementia, that restricts the individual's ability to perform normal daily tasks or that threatens the capacity of the individual to live independently. (HFS 10.13(25m)).

PHYSICAL DISABILITY means a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, which results from injury, disease or congenital disorder and which significantly interferes with or significantly limits at least one major life activity of a person" (WI Statutes 15.197(4)(a) 2).

"Major life activity" means any of the following: A. Self-care. B. Performance of manual tasks unrelated to gainful employment. C. Walking, D. Receptive and expressive language, E. Breathing, F. Working, G. Participating in educational programs, H. Mobility, other than walking, I. Capacity for independent living." (WI Statutes 15.197(4)(a)1).

FEDERAL DEFINITION OF DEVELOPMENTAL DISABILITY: A person is considered to have mental retardation if he or she has – (I) A level of retardation described in the American Association on Mental Retardation's Manual on Classification in Mental Retardation , or (ii) A related condition as defined by 42 CFR 435.1009 which states, "Person with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:

(a) It is attributable to
  (1) Cerebral palsy or epilepsy or
  (2) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.
(b) It is manifested before the person reaches age 22
(c) It is likely to continue indefinitely
(d) It results in substantial functional limitations in three or more of the following areas of major like activity: Self-care; Understanding and use of language; learning; mobility; self-direction; or capacity for independent living.

STATE DEFINITION OF DEVELOPMENTAL DISABILITY: "'Developmental disability' means a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, mental retardation, or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mental retardation, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. 'Developmental disability' does not include senility which is primarily caused by the process of aging or the infirmities of aging" (WI Statutes 51.01(5)(a)).

DEMENTIA means Alzheimer's' disease and other related irreversible dementias involving degenerative disease of the central nervous system characterized especially by premature senile mental deterioration and also includes any other irreversible deterioration of intellectual faculties with concomitant emotional disturbance resulting from organic brain disorder (WI Statues 46.87(1)(a)).

TERMINAL CONDITION: means death is expected within one year from the date of screening.

SEVERE AND PERSISTENT MENTAL ILLNESS: means a mental illness which is severe in degree and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, which may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support and which may be of lifelong duration. "Chronic mental illness" includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include organic mental disorders or a primary diagnosis of mental retardation or alcohol or drug dependence. (HFS 63.02(7)).

NO TARGET GROUP: means the person does not appear to meet any of the statutory definitions for a LTC FS target group.